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Office: 281.315.3839 Fax: 281.598.5499

MEDICAL RECORD RELEASE AUTHORIZATION FORM
FAX: 281-598-5499

PATIENT INFORMATION

Name: _____ DOB: _____

Tel: _____ Email: _____

PLEASE RELEASE MY MEDICAL RECORDS FROM:

Provider: _____

Fax: _____ Tel: _____

Address: _____

INFORMATION TO BE RELEASED: (CHECK ALL THAT APPLY)

- ☐ Complete Medical Records ☐ Visits and Encounter ☐ Laboratory Reports/Pathology Reports
☐ Radiology Reports ☐ Operative Reports ☐ Consultation Reports
☐ Emergency Room Reports ☐ Other: _____

PURPOSE OF RELEASE:

- ☐ Personal use ☐ Continued Medical Care ☐ Legal Reasons
☐ Insurance ☐ Disability determinations ☐ Other: _____

PLEASE SEND THEM TO:

LUNA THERAPEUTICS
7900 Fannin St, Suite 2620, Houston, TX 77054
FAX: 281-598-5499 TEL: 281-315-3839

AUTHORIZATION AND EXPIRATION

I understand that this authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I request that this authorization remain in effect until _____.

I understand that I may revoke this authorization at any time by providing written notice to this practice. I also understand that the written revocation must be signed and dated with a date that is later than the date of this authorization. The revocation will not affect any actions before the receipt of the written revocation.

PATIENT SIGNATURE, PARENT OR LEGAL GUARDIAN

DATE

RELATIONSHIP TO PATIENT

Alexander Wainwright, MD
Jonathan Faro, MD, PhD